γ-IFN. The rare effect of α-IFN on the growth of the eyebrow in the present patient might be due to the altered immune function of the follicle.

Kouichi Ariyoshi
Kenji Shinohara
Xu Ruirong
Division of Hematology, Department of Medicine, Yamaguchi Prefecture Central Hospital, Hofu, Japan

References

1. Mughal TI, Robinson WA, Thomas MR, Speigel R: Role of recombinant interferon alpha and cimetidine in patients with advanced malignant melanoma. J Cancer Res Clin Oncol 114:108–109, 1988.
2. Mughal TI, Thomas MR, Robinson WA: Role of recombinant alpha-interferon in the treatment of advanced cutaneous malignant melanoma. Oncology 48:365–368, 1991.
3. Case Records of the Massachusetts General Hospital (Case 10-1987). N Engl J Med 316:606–618, 1987.
4. Randall VA, Thornton MJ, Hamada K, Messenger AG: Mechanism of androgen action in cultured dermal papilla cells derived from human hair follicles with varying responses to androgens in vivo. J Invest Dermatol 98:86S–91S, 1992.
5. Conlon KC, Urba WJ, Smith JW, Steis RG, Longo DL, Clark JW: Exacerbation of symptoms of autoimmune disease in patients receiving alpha-interferon therapy. Cancer 65:2237–2242, 1990.
6. Skoutelis A, Freinkel RK, Kaufman DS, Leibovich SJ: Angiogenic activity is defective in monocytes from patients with alopecia universalis. J Invest Dermatol 95:139–143, 1990.
7. Harper JI, Kendra JR, Desa IS, Staughton RCD, Barrett AJ, Hobbs JR: Dermatological aspects of the use of cyclosporin A for prophylaxis of graft-verses-host disease. Br J Dermatol 110:469–474, 1984.

Adult T-Cell Leukemia Diagnosed After 22 Years

To the Editor: Adult T-cell leukemia (ATL), first proposed as a new disease entity in 1977 [1], is now known to be caused by human T-lymphotropic virus type I (HTLV-I) [2,3]. Presumably, we failed to recognize ATL for many years before 1977 in Japan where HTLV-I is endemic. How many years back we can trace ATL cases is an interesting subject. In 1973, we treated a 38-year-old Japanese woman who presented with characteristic clinical features of ATL such as abnormal T-lymphocytosis with indented or lobulated nuclei, lymphadenopathy, hepato-splenomegaly, and rapidly fetal outcome with histologically proven cytomegalovirus pneumonia. At that time, we were puzzled by the disease. After 22 years, we were able to detect HTLV-I proviral sequences in DNA extracted from her unstained blood smears by polymerase chain reaction using primers specific for the pX region (Fig. 1) [4]. Although her serum was not available for antibody testing, the result strongly suggests that our patient had ATL and that this technique is worth trying in archival tissue samples from patients suspected to have had ATL.

Hirokuni Taguchi
Tatsushi Miyagi
Isao Miyoshi
Department of Medicine, Kochi Medical School, Kochi, Japan

References

1. Uchiyama T, Yodoi J, Sagawa K, Takatsuki K, Uchino H: Adult T-cell leukemia: Clinical and hematologic features of 156 cases. Blood 50:481–491, 1977.
2. Poiesz BJ, Ruscetti FW, Gazdar AF, Bunn PA, Minna JD, Gallo RC: Detection and isolation of type C retrovirus particles from fresh and cultured lymphocytes of a patient with cutaneous T-cell lymphoma. Proc Natl Acad Sci USA 77:7415–7419, 1980.
3. Hinuma Y, Nagata K, Hanaoka M, Nakai M, Matsumoto T, Kinoshita K, Shirakawa S, Miyoshi I: Adult T-cell leukemia: Antigen in an ATL cell line and detection of antibodies to the antigen in human sera. Proc Natl Acad Sci USA 78:6476–6480, 1981.
4. Sawada T, Iwahara Y, Ishii K, Taguchi H, Hoshino H, Miyoshi I: Immunoglobulin prophylaxis against milkborne transmission of human T-cell leukemia virus type I in rabbits. J Infect Dis 164:1193–1196, 1991.

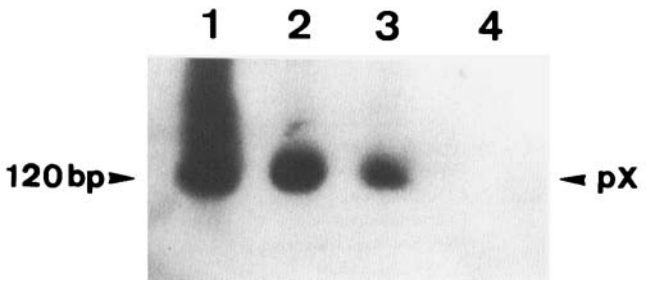

Fig. 1. Southern blot analysis of HTLV-I pX sequences amplified from peripheral blood smears by polymerase chain reaction. Lane 1, ATL patient; lane 2, present patient; lane 3, HTLV-I carrier; lane 4, H_2O.

Unscreened Transfusion Related Human Immunodeficiency Virus Type-I Infection Amongst Indian Thalassemic Children

To the Editor: Studies in India have shown that the two important population groups at risk for human immunodeficiency virus type I (HIV-I) infection are heterosexually promiscuous persons and paid blood donors [1]. The latter group give blood on payment and constitute the majority of donors in most blood banks. In addition, paid donors are from the poor socio-economic strata who usually indulge in heterosexual promiscuity. Rates of seropositivity are therefore alarmingly high in paid donors, up to 75% compared to a rate of 0.34% in other donors [1]. Transfusion of infected blood has up to 90% risk of transmission of the HIV-I infection [2]. In India, mandatory screening of all donated blood came into practice in March 1989. However, because stringent control is not always implemented, infected blood transfusion practices appear to continue with consequent fatalities.

The thalassemic clinic at Sanjay Ghandi Hospital, Manipur is a major transfusion centre in India. Here, many thalassemic children continue to receive unscreened blood from paid donors. Systematic screening for HIV-I infection of all multitransfused thalassemic children was therefore undertaken from August 1992 til November 1994 while investigating the obstetric outcome of their mothers. Preliminary results of the incidence and clinical manifestation of HIV-I infection in this high risk pediatric population are presented.

The sera of 406 multitransfused children with various types of thalssemia were screened for HIV-I antibodies by competetive ELISA (Wellcozyme Recombinant, Wellcome Diagnostic, UK). Confirmatory Western blot was performed on all ELISA positive sera.

Immunologic status of the seropositive children was evaluated by

1. Absolute lymphocyte count